DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03 - 20**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
~~**September 1, 2003**~~ * 1 July 03

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2004** $ ~~**($382,071)**~~ **($3,352,426)** *
b. FFY **2005** $ **($382,071)** **($12,404,020)** *

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:
This amendment separates clinical laboratory reimbursements from the physician reimbursement methodology, eliminates ambulance reimbursements at a flat rate but continues the reimbursement rate that includes mileage, and removes the requirement that clinical laboratory services rates be updated each year in accordance with the Medicare Fee Schedule.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jason Cooke by Rodney Lee

13. TYPED NAME:
Jason Cooke

14. TITLE:
State Medicaid/CHIP Director

15. DATE SUBMITTED:
September 26, 2003

16. RETURN TO:
Jason Cooke
State Medicaid/CHIP Director
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 26 SEPTEMBER 2003

18. DATE APPROVED: 4 NOVEMBER 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 JULY 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
ANDREW A. FREDRICKSON

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

* Pen and Ink Change Based Upon 10/20/04 E-mail
* Pen and Ink Change Based on 10/27/04 E-Mail

FORM HCFA – 179 (07-92)

Attachment to Blocks 8 & 9 to HCFA Form 179

Transmittal No. TN 03-20, Amendment No. 655

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Attachment 4.19-B	Attachment 4.19-B
Page 1	Page 1 (TN 92-06)
Page 1a	Page 1a (TN 01-21)
Page 1a.1	New
Page 1a.2	New
Page 1b	Page 1b (TN 92-06)
Page 1c	New

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Texas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

HHSC uses the same reimbursement rates for both public and private providers for services covered by each methodology in this attachment, with the exception of laboratory screening services provided as part of an EPSDT/Texas Health Steps medical check-up by the Texas Department of Health (Texas Department of State Health Services effective September 1, 2004) (Items 3 and 6).

1. Subject to the qualifications, limitations, and exclusions in the amount, duration and scope of benefits as provided elsewhere in the State Plan, payment to eligible providers of laboratory services, including x-ray services, except the technical component of those services described in number 3 below, radiation therapy services, physical therapists' services, physician services, podiatry services, chiropractic services, optometric services, dentists' services, and psychologists' services are reimbursed based on an uniform, statewide, prospective payment system.

   a. The fees for covered services provided by physicians and certain other practitioners are based upon the determination of adequacy of access to health care services by the Texas Health and Human Services Commission (HHSC) or its designee, as described in this section.

      (1) There shall be no geographical or specialty reimbursement differential for individual services. HHSC or its designee reimburses high-volume public and private Medicaid providers an additional percentage payment in recognition of their vital contribution to the Texas Medicaid program.

         (i) Primary Care Providers (PCPs) are medical professionals (i.e., medical doctors, doctors of osteopathy, and independently practicing advanced practice nurses (APNs)) defined as Family/General Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics, Certified Registered Nurse Midwifes, and Family and Pediatric APNs. To receive high-volume add-on payments effective July 1, 2003, high-volume PCPs are those providers who were paid a minimum of 3,600 Medicaid units of service for the qualification period of April 1, 2001, through March 31, 2002. High-volume PCPs get a 1.9% add-on payment for all Medicaid services performed on or after July 1, 2003.

         (ii) High-volume specialty care providers are medical professionals enrolled with a provider specialty from the following list: allergy; anesthesiology; cardiovascular disease; certified registered nurse anesthetist (CRNA); dermatology; ear, nose and throat; gastroenterology; general surgery; geriatrics; hand surgery; nephrology; neurosurgery; nuclear medicine; ophthalmology; orthopedic surgery; pathology; physical medicine and

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rehabilitation; plastic surgery; proctology; psychiatry; pulmonary disease; radiology; thoracic surgery; and urology. To receive high-volume add-on payments effective July 1, 2003, high-volume specialists are those specialty care providers who provided units of service in the top 50% of total services paid within the specialty during the qualification period of April 1, 2001, through March 31, 2002. High-volume specialists get a 6.1% add-on payment for all Medicaid services performed on or after July 1, 2003.

(iii) To receive high-volume dentist payments effective July 1, 2003, high-volume dentists are those dental providers who were paid a minimum of 3,600 units of service during the qualification period of April 1, 2001, through March 31, 2002. High-volume dental providers get a 3.7% add-on payment for all Medicaid services performed on or after July 1, 2003.

(2) The fees for individual services will be reviewed at least every two years and include: (i) resource-based fees (RBFs), and (ii) access-based fees (ABFs). The fee schedule is published annually, with fee changes published in messages on provider remittance and status reports and/or in provider Medicaid bulletin articles throughout the year.

(3) Measures of adequacy of access to health care services include, but are not limited to, the following determinations: (i) adequate participation in the Medicaid program by physicians and other practitioners; and/or (ii) the ability of Texas Medicaid recipients to receive adequate health care services in an appropriate setting.

b. Resource-based fees (RBFs) are based on actual resources required by an economically efficient provider to provide each individual service and are calculated by multiplying the applicable relative value unit (RVU) times a conversion factor.

(1) A relative value unit (RVU) is the relative value assigned to each of the three individual components that comprise the cost of providing individual Medicaid services. The three cost components are intended to reflect the work, overhead, and professional liability expense required to provide each individual service. The RBF fee schedule was first established in 1992 and utilized the RVUs as specified in the Medicare Fee Schedule in effect at that time. As new services have been added, the Medicaid RVUs for those new services were based on the Medicare RVUs in effect at the time. HHSC or its designee will review any changes to or revisions of the various Medicare RVUs and, if applicable, adopt the changes as part of the RBF fee schedule.

(2) The conversion factor is the dollar amount by which the sum of the three cost component RVUs is multiplied in order to obtain an RBF for each individual service. HHSC or its designee may develop and apply multiple conversion factors for various classes of service such as obstetrics, pediatrics, general surgeons, and/or primary care services. Adjustments may be made to the conversion factor to include inflation and/or to ensure adequacy of access to health care services for Medicaid clients.

c. Access-based fees (ABFs) are developed to account for deficiencies in RBFs relating to adequacy of access to health care services for Medicaid clients and are based upon: (1) historical charges; (2) current total Medicare fee (i.e., RVU times Conversion Factor) for the individual service; (3) review of Medicaid fees paid by other states; (4) survey of providers' costs to provide the individual service; (5) Medicaid fees for similar services; and/or (6) some combination or percentage thereof.

d. Payment for services, excluding durable medical equipment, supplies, and drugs/biologicals, covered under this item are reduced by 2.5% effective September 1, 2003.

2. Ambulance services shall be reimbursed in accordance with a reasonable charge methodology. HHSC or its designee shall define and determine reasonable charges and payments as follows.

   a. A reasonable charge for a specific service shall be the lesser of:

      (1) the provider's customary charge for the specific service using the provider's 1992 Medicare customary profile, which is a record of the provider's charges made during 1991 that have been arrayed, extremes deleted, and an average customary charge calculated;

      (2) the published prevailing charges made for similar services in the geographic locality, using the 1992 Medicare prevailing profiles, which were based on charges made during 1991 and which were increased by 1.5% effective with state fiscal year 2000; or

      (3) the actual charge of the eligible provider.

   b. New ambulance providers are reimbursed at the lesser of the provider's actual charges, the 75th percentile of the applicable prevailing charges profile, or the 50th percentile of the applicable prevailing charges profile, since the provider does not have an established 1992 customary charges profile.

   c. Determination of reasonable charges, as set forth in this section and established by HHSC or its designee, shall be made in accordance with applicable federal requirements. Payments for services provided must not exceed the Medicare fee schedule.

   d. Payments for services covered under this item are reduced by 2.5% effective September 1, 2003.

3. The technical component of clinical diagnostic laboratory services, including x-ray services, performed in a practitioner's office, by an independent laboratory, or by a hospital laboratory for its outpatients shall be reimbursed the lower of the provider's usual customary charge for that service or a fee determined by HHSC or its designee. HHSC or its designee will review Medicaid fees whenever Medicare updates its fee schedule for these services, with the resulting Medicaid fees reflected in a published fee schedule. Payments for laboratory screening services provided as a part of an EPSDT/Texas Health Steps medical check-up by the Texas Department of Health (Texas Department of State Health Services effective September 1, 2004) (Item 6) are based on allowable costs in accordance with OMB A-87. Payments for services provided must not exceed the Medicare fee schedule. Payments for services provided under this item are reduced by 2.5% effective September 1, 2003.